PHILADELPHIA MEDICAL TIMES.

SATURDAY, JUNE 5, 1875.

ORIGINAL LECTURES.

CLINICAL LECTURE ON LUPUS ERYTHEMATOSUS.

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Delivered May 18, 1875.

Reported by ARTHUR VAN HARLINGEN, M.D., Chief of the Skin Clinic.

GENTLEMEN,—The patient whom we have before us, and whose case shall form the subject of my lecture to-day, presents an affection of such interest that I shall devote the greater part of the hour to its consideration. It is one which, although not very uncommon, does not often present itself developed to the extent to which we have it here. Her history is as follows:

She is a married woman, 26 years of age, with light-brown hair. The affection for which she seeks relief first made its appearance fourteen months ago, as a roundish patch, situated on one side of the nose. From this point it began to spread over the face on the same side, and, some time after, attacked the other side of the face, extending under the eyes in the form of a semicircle. Afterwards it appeared successively on the forehead above the nose, on the side of the chin, and on the right side of the head behind the ear. The disease has never shown itself in any other part of the body. The patient is of large frame, stout, well nourished, and enjoys average general health; she has gained flesh since the appearance of the skin-trouble. Her appetite is good, bowels somewhat constipated, menstrual discharge regular but scanty. She has always been subject to cold hands and feet, even in summer-time. For the last three years she has suffered from occasional headaches, occurring, perhaps, every few days or once a week. For some years past she has been troubled with seborrhœa of the scalp, and she has this trouble at present. Before the present disease broke out, the skin was remarkably free of eruption of any kind. About five years ago she had a slight attack of rheumatism, which has not been repeated. Although the disease of the face has been better and worse from time to time, yet it has never shown any tendency to disappear; it is said to be spreading slowly now from week to week. So much for the history.

Proceeding to the examination of the eruption, we observe that it consists of numerous variously-shaped patches, mostly roundish, the size of a split pea and larger, many of which have coalesced and form patches of greater size. The cheeks are involved symmetrically, the area of disease on either side being perhaps the size of the palm, and extending from the lower eyelid almost to the ramus of the jaw. The nose is partially invaded; the bridge and the tip being especially attacked. The alæ of the nose are free, as well as the region about the mouth, chin, and the red part of the lips. Beneath the lower lip and around the chin there are circular, isolated patches, from the size of a pea to that of a cherry. A similar patch may also be noticed back of the right ear; the lobes of the latter are free. The eyelids are partially invaded, the spaces between brow and lid being symmetrically occupied by elongated patches, which also extend around the inner canthi, close to the conjunctivæ. On the forehead you will notice two irregularly-shaped, linear patches, extending outwards from the nose half-way up towards the scalp.

The patches over the cheeks are purplish-red in color, and are covered with very fine, adherent, greenish-white and yellowish scales. The mouths of the sebaceous glands are everywhere open. The skin, moreover, has an inflammatory appearance, feels hot at times, and occasionally itches and burns very severely. The itching has been a more or less constant symptom, but has not manifested itself more of late than earlier in the history of the disease. The line of demarcation is everywhere well marked; the diseased patches, although but very little elevated, terminate abruptly against the sound skin. The isolated, circular patches, which are the most recent manifestations of the disease, also show a sharply-defined border, likewise but slightly raised. Our patient tells us that the patches vary considerably in color at different times, occasionally becoming quite purplish, at other times of a much paler hue. It should be remarked that she experiences no pain.

The course of the affection has been intermittent; it has increased by attacks taking place every few weeks, at which time the disease would spread considerably in a few days, and then remain quiescent during the interval.

Now, having heard this woman's history, and having made a careful examination of the appearances presented, let us leave the investigation of this individual case, and go into a consideration of the affection in general.

The affection before us is known under several different names: lupus erythematosus or erythematodes, seborrhœa congestiva, etc. Biett, who first described it many years ago, gave it the title "*lupus qui détruit en surface*," in view of the fact that while the disease is a destructive one as regards the cutaneous tissues, its action is not deep like that of lupus vulgaris, but is confined to the upper layers of the skin. The name seborrhœa congestiva was originally given by Hebra, who regarded the seat of the disease to be in the sebaceous glands, but he afterwards modified his views on the subject of its pathology and abandoned this name for that by which the affection is now generally known, lupus erythematosus, erythematous lupus.

Lupus erythematosus is included under the class of "cellular new formations." Its usual seat is upon the face, where it most commonly shows itself first on the bridge of the nose, spreading out over the cheeks on either side, so as to form the appearance of a butterfly, a simile first noted by Hebra. A word as to color. It is variable, sometimes light, again dark; very often it is a beefy red, like inflammatory psoriasis.

The patches are always more or less covered, as we have seen, with scales, whitish, yellowish or greenish in color, and very adherent. The disease is invariably superficial in character; it never goes on to ulceration; there is never any moisture, and the appearance of a given patch is always the same from one month to another.

Lupus erythematosus is, as I have said, usually confined to the face, for which locality it has a strong preference, and particularly for the cheeks. It, however, does occur on the body. Occasionally we see it on the red portion of the lips, as in this photograph which I show you.

Lupus erythematosus is a disease of adult age; it never makes its appearance before puberty. In this respect it is quite different from lupus vulgaris, which is apt to make its appearance at an early age. This is an important point, for these diseases are often confounded.

The causes which produce the disease are obscure, but are at times the same as those which bring on ordinary seborrhœa, *e.g.* anæmia, chlorosis, and the like. The French have given the disease the name (among others) of Scrofulide Érythémateuse, but this often proves a misnomer: there is certainly no sign of scrofula in the case before us; our patient is a fine, hearty young woman, showing no sign of any constitutional taint whatsoever.

As regards diagnosis, the tissues involved, the shape and locality of the patches, the characteristic greenish, strongly-adherent scales, are all so peculiar that in most cases there can be but little difficulty.

There are, however, five diseases with which, under some circumstances, lupus erythematosus might be confounded. The first of these is lupus vulgaris. In this affection, however, we find papules and tubercles almost always present; neither of these are found in lupus erythematosus. The fact mentioned a little while ago, that our disease is one of adult life, while lupus vulgaris always begins in the young, may also be remembered. Both diseases are apt to attack the face, but the formation of tubercles which subsequently break down into ulceration would decide the matter. The brownish crusts found occasionally over the lupus vulgaris patch might be mistaken for the scales of lupus erythematosus, but a closer examination would show that in the first case we have *crusts* formed of dried pus, while in the other we have epithelial *scales*.

Secondly, we may sometimes mistake lupus erythematosus for psoriasis. The general appearance of the eruption before us is not unlike that of a patch of psoriasis, but we should hardly be likely to find the latter disease in one large area on the face, but rather in a number of smaller patches. Besides this, close examination of the scales would show a very decided difference. Those of psoriasis are friable, flat, superficial and easily picked off, while the scales of lupus erythematosus are exceedingly adherent, and when removed show villous projections consisting of the contents of sebaceous glands, with occasionally a cast of their lining membrane.

Thirdly, the disease before us resembles at first glance certain forms of syphilis, but upon closer inspection we could hardly fail to exclude this. The history and course of the affection, moreover, would aid in deciding the matter.

Fourthly, we might confound lupus erythematosus with eczema, but, although a superficial glance might cause us to hesitate a moment, an examination would reveal the absence of the characteristic eczematous weeping and crusting; the glandular involvement would in addition be quite sufficient to distinguish them.

Fifthly, lupus erythematosus has occasionally been mistaken for tinea circinata. The history of the disease, however, would show that its course is far different from that pursued by ring-worm of the face. Microscopic examination of the scales would serve to dissipate any doubt.

Now, as to the pathology of the disease. It begins in the glands of the skin, chiefly the sebaceous glands. If you examine the case before us, you will notice that in certain places the sebaceous follicles are enlarged, plugged up with altered sebaceous matter, and covered by an adherent scale. Beyond the region of the disease itself, you may see sebaceous glands congested and swollen, which will in time become new centres of disease. The greenish color of the scales is in part due to their natural color, in part the result of admixture with dirt.

The disease-action begins by an infiltration or deposit of fine cells in the corium, and particularly about the sebaceous glands. They are minute, highly refractive, and roundish, not unlike granulation-cells. They are very persistent. Lupus erythematosus is a markedly inflammatory disease; itching and burning are frequently (though not always) observed. The extent of these symptoms is variable.

They are aggravated by different external causes. Our patient, for instance, notices that when she goes out into the open air, and particularly when her face is exposed to the wind, they are more severe. I have frequently observed the same fact in other cases. The course of the disease is uncertain; it suddenly spreads a few lines or more, and then stops for a time. It is during this rapid growth that the itching and burning are most violent.

As regards prognosis and treatment; cases of this disease are apt to prove exceedingly stubborn, yet differ greatly in this respect: one may get well quite rapidly, while the next will resist all treatment. Occasionally patients who are attacked in so severe a manner as in the case before us are carried off by some intercurrent disease, as erysipelas; this, however, is not common, nor is it explainable. I simply present it as a fact which has been noticed by several good observers (Hebra, Kaposi).

There is no specific treatment for lupus erythematosus; we must manage each case as may prove best for it. Among the internal remedies most likely to prove useful are cod-liver oil, arsenic, iron, and iodide of potassium, together with all those means ordinarily employed for the purpose of raising the tone of the system and improving nutrition.

As regards external remedies, stimulant and caustic applications, and particularly alkalies, are

most useful. Among the best of the latter is the ordinary sapo viridis or soft soap (containing about four per cent. of caustic potassa in excess). This may be rubbed into the diseased patches with the aid of a flannel rag, a little warm water being added from time to time. After the scales and débris are thoroughly cleaned away, the surface of the patch may be washed with pure water, dried, and some ointment, preferably the unguentum hydrargyri, applied, spread upon cloths of proper size and shape. These applications should be made twice daily. We may substitute the preparation known as "spiritus saponis alkalinus," a solution of sapo viridis in absolute alcohol, for the soap, and in some cases with advantage.

Instead of mercurial ointment, other preparations of a somewhat more stimulating nature may be employed. Among these the ointments of red iodide of mercury, sulphur, and iodide of sulphur, may be mentioned.

All these should be tried before having recourse to stronger applications; but when the milder forms of treatment have failed, the strong caustics may be employed. Solution of caustic potassa, one part to four or eight of water, may be advantageously applied with a small swab, rubbing the diseased surface, and quickly applying vinegar or dilute acetic acid to neutralize the alkali and prevent excessive caustic action. Of course, where there is a large patch, only a portion should be gone over at any one time; the eschar which forms may be dressed with water, or olive oil on lint. The cauterization may be repeated every week or so, until the whole diseased tissue has been destroyed. Of course this is a last resort, but it usually answers when everything else fails.

A strong solution of carbolic acid, or even the crystals themselves, may also be used. The application, however, is a very painful one, and the smarting lasts some hours.

In the case before us we shall begin by giving our patient the iodide of potassium in the dose of ten grains thrice daily, and shall, for the present, use no local treatment.

Finally, let me advise you to gain your patient's confidence before beginning any course of treatment. We shall tell this woman that the affection is a tedious one, may last a long time, months, or even years, and let her commence with a full appreciation of the necessity of patience. On the other hand, we shall make her understand the necessity of efficient and sustained treatment. Lupus erythematosus never, or at least very rarely, gets well spontaneously.

INSOLATION DURING PREGNANCY (*American Journal of Obstetrics*, May, 1875).—Dr. M. B. Wright reports a case in which during the three weeks preceding labor the temperature of the mother was greatly elevated, pulse 120 to 140, intense headache. These symptoms all disappeared within twenty hours after the delivery of a fœtus two or three weeks in advance of full term, weighing about six pounds, and similarly overheated. The liquor amnii and placenta were also found to be much above their usual temperature. No definite cause for these peculiar phenomena was discovered.

ORIGINAL COMMUNICATIONS.

PHOTOGRAPHIC ENLARGEMENTS OF MICROSCOPIC OBJECTS.

BY CARL SEILER, M.D.,
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Read before the Biological and Microscopical Section of the Academy of Natural Sciences, and recommended for publication in the Philadelphia Medical Times.

THE processes of different workers in microphotography, with all the minute details and description of the apparatus used, have repeatedly been published, so that I have to ask your indulgence for bringing again a new apparatus to your notice.

The first experiments I made in this direction were attended with very little success, which, however, did not discourage me. They were made with a complete microscope and camera,—that is to say, eye-piece and photographic objective were retained, while reflected sunlight was used for illumination. In continuing my experiments the objective of the camera and the eye-piece were found useless, and were discarded, and without them better negatives were obtained. The great objection was the motion which resulted from even the slightest tremor of the house, caused by passing wagons or by the walking of persons in rooms above or below. This motion and its consequences were removed to a great extent by discarding the body of the microscope, and by using the objective in connection with the camera, or, rather, a long wooden box. In this way the microscope and the camera were converted into one instrument. But two difficulties presented themselves in using this new form of apparatus,—viz., that of obtaining the picture on the ground glass in focus, and that of illumination of the object. The first was overcome by using a quarter portrait-tube, and putting in the place of the front combination a disk with a central opening, into which the objective was screwed, the back combination of the tube having been removed. Then by passing a resined cord over the mill-head of the tube I was enabled to bring the object in focus, being at some distance from it. This was done by pulling at the ends of the cord, and thus revolving the mill-head, which caused the approximation of the lens to the object. A stage was then constructed by extending an arm in front of the tube with a perforated plate at right angles to it, upon which the specimen was secured by clamps. For illumination, a large concave reflector was placed at some distance in front, and so bringing the light to a focus directly in front of the object.

This form of apparatus I did not find necessary to alter materially; all I did to improve it was to make the body of the camera of paper, and extensible, so that it can be lengthened to ten feet, and to add a movable stage, which, moved by long rods, enables me to bring any part of the object into the field. For the cord I substituted a rod and two friction-gear wheels, with which I can focus with considerable fineness. The main difficulty, however, was, and still is, the illumination; and it was only

after a long series of experiments that I could obtain tolerable results.

The first condition, at least for histological preparations, is that the light should be absolutely central. Even then the image on the ground glass will be a confused one, with bright lines and dark shadows, and single cells or blood-disks will show three and four outlines, the rays of light being bent in their course through the object. It has been recommended to interpose a piece of ground glass between the reflector and the object, in order to diffuse the light and so get rid of this difficulty. But I found that this does not answer the purpose, as it reduces the penetrating power of the objective, and also takes away the *crispness* of the picture, if I may use this expression. It does, however, flatten the field very considerably, and is of great advantage in vegetable and insect preparations, where the lines are comparatively coarse. Rendering the light monochromatic by means of a solution of ammonio-sulphate of copper contained in a glass cell obviates this trouble to a certain extent, and has also the advantage of bringing the chemical and the visual focus almost in the same plane, as well as of absorbing the heat-rays which would otherwise destroy the object. As this solution becomes turbid if the cell is not perfectly tight, and as it penetrates almost any substance, I had at first considerable difficulty in keeping the solution clear. I now use a cell made of glass in the following manner: a hole is ground into a one-fourth inch thick piece of plate-glass, extending to the margin, with a conical opening. Then two pieces of thin plate-glass are cemented on each side of the thick glass by means of a mixture of glue and molasses. In this way a circular cell is formed, with a funnel-shaped opening on the top, through which the solution may be introduced and then the opening closed by a tight-fitting cork. If now this monochromatic sunlight is concentrated by means of an achromatic condenser upon the object, the result on the ground glass is far better in every respect than without the condenser. It must, however, be used with caution, so as not to introduce too much light, as in that case it is impossible to give the sensitive plate the proper time of exposure.

The greatest advantage, however, I derived from introducing diaphragms into the condenser and objective, and also into the camera itself, in this way cutting off all superfluous light. As the German lenses, which I am compelled to use, do not allow the introduction of a stop between the front and back lenses, I fitted a cap with a small opening over the front lens, and another over the back lens. These stops increase the penetrating power of the objective considerably, and also make the picture appear on the ground glass almost as sharp and crisp as it is seen in the microscope itself.

It has also been recommended to take the focus on clear plate-glass with an eye-piece, because the surface of the ground glass is too rough to allow a slight difference in focus to be seen, while it is readily perceived in the negative. But focussing with the eye-piece is not only very tedious, but also more uncertain than even the roughest ground glass; at least it has proved so in my hands. I use for a focussing-screen a piece of plate-glass which has been varnished on one side, and then rubbed with alcohol, which makes it slightly turbid,—not enough to prevent transparency, but sufficient to make the picture apparent.

It is as a matter of course most important that only the best preparations should be used, the quality of the objectives being of far less importance. Most of the specimens which I used, and of which I placed a few photographs on the table, I obtained through the kindness of Dr. J. G. Hunt. The preparation of the negatives and prints is the same as in ordinary photographic work, with the exception that the negative cannot be made strong enough by mere development with iron, and has therefore to be intensified in order to print well.

It is hardly necessary for me to say that the advantages, both for teachers and students, which may be derived from good photographs of microscopic objects, are very great, as drawings, no matter how well and faithfully executed, always can give only that which the artist or draughtsman has seen; and we all know how very deceptive appearances in the microscope sometimes are, so that even those who are perfectly familiar with the instrument and object are often misled,—how much more easily those who are not familiar with microscopy, and who are only occasionally required to make a drawing of what they see in the instrument!

Micro-photography, however, is as yet in its infancy, and the results obtained are by no means perfect; but they are encouraging, and I hope that by perseverance pictures may be obtained which will be equal to the one formed on the retina of the human eye.

THE MOLOCH OF TRADITION.

BY BENJAMIN LEE, A.M., M.D.

AT the meeting of the Philadelphia County Medical Society of February 11, 1874, I had the honor to present a paper entitled "The Practical Identity of True Croup and Diphtheria." I had first written "The *Essential* Identity," but changed it, thinking by softening a little the positiveness of its assertion to provoke less opposition in the minds of my hearers to the doctrine which I desired to maintain. I wish to preface this brief addendum to that paper (which subsequently appeared in this journal) with the statement that I consider the identity essential as well as practical, and practical because essential. My aim, then, was not so much to present my own views or to frame an argument in their support, as to show how great a weight of authority could be brought to bear on that side of the question from the contemporary writings of European physicians, especially Continental. I confess I was unprepared for the entire lack of concurrence with which the proposition was received. My heavy ordnance, borrowed for the occasion, produced no more impression on the Society than a carefully-mounted battery of pop-guns on an iron-clad. While there was no lack

of kindly commendation of the labor displayed in the preparation of the essay, it was evident that the theory broached was unanimously condemned as rank heresy. Even the accomplished author of the paper on "Tracheotomy in its Relations to Croup and Diphtheria," which followed soon after, on whom, as a man of advanced views, I supposed I could count as a second, showed himself still bound with the cords of dogmatic teaching, a firm believer in the purely sthenic inflammatory character of membranous croup.

For the sacrifice of what hecatombs of lives is this miserable word inflammation, or the misuse of it, responsible! And if we are now to have a revival of indiscriminate phlebotomy, how gory will be the altar of the Moloch of tradition! I have since had gratifying evidence, however, that certain practical hints which I threw out in regard to the early use of antizymotics and tonics, and the avoidance of all depressant measures at the outset of every case of acute faucial disease, before it has had time to differentiate itself, did not fall altogether dead. I simply wish now to call the attention of those who were kind enough to listen to or read the former somewhat lengthy article, to the fact that the ranks of those who maintain the specific character of true croup as simply a form of diphtheria have recently received two most powerful accessions in England.

From an article by Sir William Jenner, entitled "Clinical Lecture on Croup and the Diseases that resemble it" (*Lancet*, January 16, 1875), I make the following extracts, and I desire to say that they are in no sense garbled, but represent the opinions of the distinguished author as honestly and exactly as the entire article would do:

"Membranous inflammation of the larynx—inflammation, that is, attended by the presence of lymph on the surface of the mucous membrane of the larynx—is croup. This is a peculiar form of inflammation, as the presence of the lymph proves. . . . The inflammation is a so-called specific inflammation. . . . Diphtheria is an acute specific disease, attended by inflammation of the pharynx, having, as its result, exudation of lymph. . . . From the pharynx it may spread down the trachea and into the bronchi. So that in diphtheria we get not unfrequently membranous inflammation of the larynx. But membranous inflammation of the larynx, I have told you, is croup. Is there, then, a membranous inflammation of the larynx distinct from the acute specific disease, diphtheria? Are there a true croup and a diphtheritic croup? Certainly, if you were to place in the hands of the best pathologist the larynx of a child who had died from membranous inflammation of the larynx, the so-called idiopathic croup, and that of one who had died from a true diphtheritic inflammation of the larynx, he would be unable to distinguish the one from the other. There is no anatomical character by which he could say, 'This is true croup; this is diphtheritic inflammation of the larynx.' But it is beyond question that true diphtheritic inflammation may be limited to the larynx; that in exceptional cases the pharynx escapes the exudation. Seeing, then, that there are no anatomical characters to distinguish the one disease from the other, are there any clinical characters by which the two affections may be separated? It has been supposed that the presence of albumen in the urine would be sufficient, and I formerly laid much weight on this distinction. But later years have satisfied me that in cases which present all the characters of true croup, which are sporadic, spread to no other person in the house, come on apparently from exposure to cold and damp,—that in such cases albumen may be present in the urine. It has again been urged that true croup has no tendency to spread; but this manifestly should no more separate a single case from the diphtheritic croup than should a single case of scarlet fever, because it did not spread, be separated from other cases of scarlet fever. The cause, again,—the fact that some cases of croup come on after distinct exposure to cold and wet,—cannot be sufficient to separate croup from diphtheritic croup, for it is beyond question that a considerable number of cases of diphtheria do, to all appearance, at least, date their origin from exposure to cold and wet. I have seen several solitary cases of true diphtheria thus originating, not spreading, or spreading to other persons in the house, as the case may be. So my opinion has undergone some modification, and I am inclined now to the belief that there is no such disease as idiopathic simple membranous inflammation of the larynx. I say I am inclined to this belief. I am not sure that it is true; but, as I formerly thought that the weight of evidence was in favor of their non-identity, I am now inclined, from my further experience, to think that the two diseases are really identical; that the so-called true croup is really diphtheria."

It will be seen further on, however, that this bias of opinion is sufficiently strong to make him willing to base his therapeusis upon it. "But, believing, as I now do," he says, in regard to diagnosis, only a few paragraphs after this modest disclaimer of positive decision of the question, "believing, as I now do, that all croup is but a local manifestation of the general disease, diphtheria, it would matter but little, as regards the diagnosis, whether the pharynx were the seat of membranous inflammation or not. . . . Holding the views which I now do, you will see at once that I should discard from the treatment of croup all those heroic remedies that were formerly regarded as indispensable,—leeching, mercurializing, antimonizing,—and I should advise you to treat it on the same principles as you would treat diphtheria with exudation commencing in any other part."

No comment is necessary as to the deference which is deservedly paid to the opinions of the distinguished man just quoted, especially in regard to this class of diseases, in his own country.

Not less clear and pronounced is the testimony borne by Dr. George Johnson, in the same number of the *Lancet*, in a paper on "Certain Points relating to the Etiology, Pathology, and Treatment of Diphtheria." . . . "I wish to express emphatically my entire concurrence in the conclusion long since arrived at by Bretonneau, Trousseau, and all

the leading French pathologists, that all cases of so-called croup which are associated with the formation of false membranes in the air-passages, are essentially diphtheritic; and, on the other hand, that what we in this country call inflammatory croup or catarrhal laryngitis never results in the formation of false membrane. It is surprising that practitioners of large experience can have any doubt upon this subject; yet we find even in some of the most recent English text-books that perplexing attempts are made to distinguish between what the authors call 'true membranous croup' and diphtheritic croup. The attempt is hopeless and most confusing to the student, for it is certain that membranous croup and laryngeal diphtheria, as we now see them, are one and the same disease. . . . If, as some writers suggest, there be a form of membranous croup which is neither the result of simple inflammation nor of the diphtheritic poison, I can only say that I have never met with the disease."

PHILADELPHIA, May 17, 1875.

TRANSLATIONS.

RHEUMATIC FACIAL PARALYSIS.—Prof. Erb, of Heidelberg, describes (*Deutsches Archiv für Klinische Medicin*) three clinical varieties of rheumatic palsy of the portio dura, essentially differing in severity, duration, and amenability to treatment. Electricity, the general therapeutic resource in this affection, he considers as affording also valuable aid in the diagnosis and prognosis; as the individual cases show striking points of difference in the behavior of the affected nerve and paralyzed muscles under the galvanic and faradic currents.

In a certain proportion of cases the electro-excitability of the nerve and muscles remains completely normal during the entire course of the disease; perhaps, on the second or third day, there is slightly increased sensitiveness, but it is transitory and shortly disappears; at no time is there any decrease in the qualitative or quantitative electrical reaction.

The electrical condition, in another set of cases, differs most characteristically from the preceding. The nerve, in a few (four to six) days after the onset of the disease, shows a rapid decline in its response to the application of the faradic and galvanic currents, so that soon after (ninth to twelfth day) the electro-motility is completely lost, and generally so continues until the return of some power of voluntary motion, when it slowly resumes its normal state. Meanwhile, important changes occur in the muscles; the faradic electro-muscular contractility lessens, until it finally disappears, as in the nerve; but though the susceptibility to the galvanic current sinks to a certain point in the first week, in the course of the next, or in the third week, it increases to far above the normal, and undergoes material qualitative changes: these anomalies disappear only very gradually and slowly. The clinical course of this variety assimilates the results produced by experimental destruction or division of the trunk of the facial nerve in animals, and the author, on that account, considers that when they occur, a complete degeneration, resulting in the loss of the electro-excitability of the nerve, is present, and that only with such an alteration would these characteristic changes occur in the muscles, which symptoms he groups, for this reason, under the title of the "degeneration-sign" (*Entartungsreaction*). Thus is this form, which he terms the "severe form," in contradistinction to the first, characterized in a manner most marked and evident. Although it is not fully matured until the termination of the second or in the course of the third week, yet, if during the first, or at its end, a marked sinking of the farado-excitability of the nerve occurs, the subsequent changes may, generally speaking, be predicated with certainty, and the diagnosis made definitely between this and the light form in which the electrical condition is normal throughout.

The prognosis of the "light form" is absolutely favorable. In the course of three or four weeks recovery will take place, independently of treatment, and with or without electricity. This class of case is sufficiently large to correct the still prevalent but erroneous idea that the early application of electricity may change a light form of facial palsy into a severe one; it likewise controverts the opinion of C. Paul, that a facial paralysis that first comes under electrical treatment after the tenth day will be tedious and stubborn.

Experience teaches that in all those cases which show the "degeneration-sign," the prognosis is relatively an unfavorable one; the disease lasting from weeks to months, and, in many cases, after years have passed traces of the paralysis will be still evident in the features. This is properly termed the "severe form," and it is well, when treatment is commenced, to warn the patient of the possibility of a long duration of the disease. It is so much the more needful because we are unacquainted with any remedy that is in a position, with any certainty, to shorten materially the wearisome course of the disease, electricity *not* excepted.

Abundant experience, confirmed by careful observation, teaches, however, that exceptions occur, and that there is yet another class, which occupies an intermediate position between the two mentioned, in reference to the electro-dynamic changes and the duration of the disease. This "middle form" is characterized by the appearance of only an unimportant decrease, but never a complete loss, of the faradic and galvanic excitability of the nerve; whilst, apparently, the electrical condition of the muscles passes through the same changes as in the severe form. The prognosis of cases of this kind is also favorable; recovery follows in a few weeks, but not so soon as in the light form.

To distinguish these three forms in practice with any certainty, requires careful electrical examination. With the induced current, however, the severe form may be distinguished from the other two, at the end of the first week, by the material or complete loss of the irritability of the nerve. It is more difficult to pronounce between the others; but if the response to the current at the end of the first or beginning of the second week be positively though slightly reduced, the middle form is present; if it remain normal, we have to deal with the light form. The course of the succeeding week, at all events, will verify or correct the diagnosis.

In seeking for an explanation of the fact that in the mediate form such marked change may occur in the muscles without alterations in the nerve of corresponding gravity, the author refers to some physiological experiments made by Ziemssen and Weiss, in which the results were analogous to the symptoms occurring in this form. These observers found that a light contusion of the nerves caused a transient paralysis, which passed off in a few days, during which the faradic excitability of the nerve sank a little but was not lost, whilst the increase and qualitative changes occurred in the muscles just as in the cases of degeneration of the nerve. Unfortunately, the histological observations in connection with these experiments were never published.

The author next takes up the question as to whether it is possible to locate the exact anatomical position of

the nerve-lesion producing the paralysis. It is generally conceded that this cause is a peripheral one, that the nerve is affected after it leaves the brain, and from the fact that, soon after its exit from the stylo-mastoid foramen, the nerve breaks up into the facial branches, all of which are generally involved in this disease, it is considered that the nerve must be affected in the Fallopian canal or in its immediate vicinity. He then takes up in succession the different branches given off at known intervals from the nerve; and, since destruction or disease of the nerve-trunk at any one point would cause paralysis of the branches below that point without involving those above, he proceeds to consider the probability of determining the site of the lesion in any individual case by means of the participation, or not, in the paralysis of these different branches of the nerve.

This leads him into a discussion of the function of each branch, and into quite an extended and interesting one in reference to the anatomy of the chorda tympani nerve. After carefully reviewing the question and referring to numerous recorded cases, he concludes that the weight of testimony is in favor of Schiff's view: that the filaments of the chorda tympani, after being received by the trunk of the facial from the lingual, apparently pass out again from the facial at about the level of the geniculate ganglion (intumescentia ganglioformis) and return to the trigeminus, apparently, by several routes (greater superficial petrosal nerve, spheno-palatine, and otic ganglia, etc.), and, with its trunk, return to the brain. What in detail these routes are in the human economy does not seem to be sufficiently established: apparently, individual peculiarities exist; it is possible that in some a part of the fibres take a peripheral course and return to the trigeminus by means of the inosculation existing between a branch of the facial and the auriculo-temporal branch of the fifth. This would appear to have been the condition in two surgical cases, where, after extirpation of the parotid gland, some impairment of taste appeared in the anterior two-thirds of the corresponding half of the tongue; however, as it is not stated how soon this occurred after the operation, it may have been due to an acute neuritis ascendens of the trunk of the facial, which secondarily involved the chorda tympani.

He concludes that in many cases of facial paralysis it is possible to locate the lesion approximately, although it is evident that such a pathological process would not necessarily be limited to one point, but might, in the course of the disease, extend along the nerve, or even affect a considerable portion of it, so as to give the appearance of being localized in several spots. From numerous observations, however, he draws the following practical deductions:

1. Disease of the nerve-trunk outside of the Fallopian canal will give the following symptoms: paralysis of the nerves of expression without involvement of the posterior auricular branch, or disturbance of taste or hearing, or the salivary secretion, or the position of the soft palate, etc. In exceptional cases impairment of taste may occur from the centrifugal course taken by the filaments of the chorda tympani, as before mentioned.

The cases of the "light form" belong probably to this class, and therefore, in making the prognosis, special attention should be given to the condition of the posterior auricular nerve (distributed to the occipitalis retrahens auriculæ, etc).

2. Disease of the nerve in the Fallopian canal, but below the point of entrance of the chorda tympani, is shown by palsy of the features and of the posterior auricular nerve without affecting taste, etc.

To this class the greater number of the cases of the severe form appear to belong.

3. Disease of the nerve between the chorda tympani and the stapedius is characterized by paralysis of the external branches and posterior auricular, with anomaly of taste in the anterior two-thirds of the corresponding half of the tongue, but no trouble of hearing, etc.

4. Involvement of the trunk of the nerve from the stapedius to close under the geniculate ganglion adds to the foregoing diminished action of the salivary glands increased sensitiveness in the hearing for high notes (hyperacusis, oxyokoia of Wolff), but no irregularity of the soft palate.

5. When the disease affects the locality of the ganglion itself, the point of departure of the greater superficial petrosal nerve, which, besides the major portion of the filaments of the chorda (on their route to the trigeminus, by way of Meckel's ganglion), carries the motor fibres for the palate, there is paralysis of all the external branches, impaired taste, and salivary secretion, abnormal sensitiveness of hearing, and lateral deflection of the palate. This is the only point at which these two bundles of nerve-fibres come in contact with each other.

6. A lesion above the ganglion, between it and the brain, would affect all the external and internal branches, as just above described, except that there would be *no* impairment of taste. Some few cases of this character have been reported by Ziemssen, Landowzy, Romberg, Bucklinmaier, and the author.

Prof. Erb remarks that these observations are not only available in determining with some certainty the seat of the lesion in facial palsy, but also would render valuble aid, from the involvement of the portio mollis and other nerves at the base of the brain, to the differential diagnosis of diseases of the neighboring organs, in similar affections of the middle ear, the mastoid and petrous portions of the temporal bone, the parotid gland, etc.

As to the relative frequency of these different varieties, the author arrives at what he considers a no less conclusive than striking result. In thirty-five cases coming under his own observation, twenty-three occurred in which, beyond paralysis of the external branches, no further symptoms were present. These cases, therefore, pointed to a lesion below the junction with the chorda tympani. Four cases belonged to class two; five to class four; a single one existed where the level of the ganglion was the seat of the trouble; and two cases, finally, belonged to class six.

The proportion of cases belonging to the first group is, apparently, from the literature of the subject, in reality even larger than the above would indicate, as the cases of facial paralysis without accompanying symptoms are certainly much more seldom reported than those in which they do appear.

It would hence appear that rheumatic facial paralysis is an affection which, as a rule, involves the nerve-trunk below the chorda tympani,—*i.e.*, at the lower end of the Fallopian canal, or immediately outside; and which, in a certain number of cases, extends to the chorda and the stapedius, more rarely to the geniculate ganglion, and only exceptionally, or never, affects the nerve-trunk at the base of the skull. Following the general view that such rheumatic processes are usually of the nature of a light inflammation of the neurilemma, we would then consider this disease as a neuritis facialis, limited, as a rule, to the nerve at its point of exit from the stylo-mastoid foramen, or its immediate vicinity, and which may ascend more or less far along the nerve in the Fallopian canal. The narrowness of this passage will then easily explain how an inflammatory swelling of the nerve-sheath, insignificant in itself, so frequently leads in this situation to such injurious compression and obstruction of the nerve as to find its clinical expression in the "degeneration-sign."

The author thinks that the "light form" has its

cause outside of the Fallopian canal (class one), and hence the nerve is free from the strong compression and its serious results. If the nerve be affected just inside the foramen, the "severe" or "middle" form appears according to the amount of the unavoidable compression. This would seem to be confirmed by the author's experience, as in all his cases where he suspected the presence of the severe form, the posterior auricular branch was found to be involved.

If the preceding views are correct, electricity affords a convenient means of determining more exactly the position of the exciting cause of the paralysis. If the electro-motility is unaffected (light form), the disease is to be sought for outside of the stylo-mastoid foramen; on the contrary, if the "degeneration-sign" appears (middle and severe form), then the pathological process is located inside of the Fallopian canal, and the prognosis will depend upon the amount of injury suffered by the nerve, as indicated by its behavior under electrical stimulus. F. W.

Vices of Conformation of the Anus.—At a meeting of the Société des Hôpitaux, M. Verneuil reported upon two observations presented by M. Deleus relative to malformations of the anus. In the first of these cases the anus presented two orifices separated by a vertical septum; one of these led into the rectum, while the other terminated in a cul-de-sac in the pelvis. Excision of this septum was performed.

M. Verneuil added to this observation the following one: an infant five months old, having some difficulty in defecation, was sent to the Lariboisière. Having ascertained the presence of a raphé proceeding from the scrotum and separating two orifices which led to a common anus, the surgeon made an incision, and found a stricture of the rectum, which was remedied by the daily introduction of the finger as a dilator morning and evening. After a few months, dilatation was complete, only two small tubercles remaining on the anterior and posterior walls. M. Deleus' second observation related to a young child with imperforate anus. The operation was performed immediately, and was facilitated by resection of the coccyx. The cure was rapid, but three months later prolapse of the rectum took place, which seemed irreducible. This prolapse may have been due to taking away the support of the sphincter, but Dr. Verneuil, who had performed a similar operation several times successfully, believed it due to bad hygienic conditions.—*Bull. Gén. de Thérap.*, April 30. X.

Sudden Death from Pain in a Woman with Hydatid Cyst of the Liver.—At a meeting of the Société des Hôpitaux (*Bull. Gén. de Thérap.*, April 30), M. Desnos read an account of a case occurring under his care at the Hôpital Necker, in 1865.

The patient had a very voluminous hydatid cyst of the liver, for which, without previous puncture, the Vienna paste was applied.

The evening following this application the woman died suddenly, and at the autopsy no trace could be discovered of either peritonitis or of perforation of the cyst; clots were found in the heart. It was evident that the woman had succumbed to a syncope provoked by the intense pain caused by the caustic,—a syncope superinduced by the profoundly cachectic condition of the patient. M. Desnos compared this case to one reported by M. Martineau, which differed, however, in the fact that death was brought about by an intense pulmonary congestion. This difference perhaps depended upon the circumstance that in M. Martineau's case the pneumogastric nerve was touched directly, while in that of M. Desnos the effect was upon the nerves of the life of relation. X.

Case of Complete Inversion of the Uterus.—Dr. S. Voelkel contributes the history of such a case to the *Berliner Klin. Wochen.*, March 15, introducing it by a few remarks relative to the comparative rarity of the accident.

Partial inversion is frequently reported in the medical journals; but complete inversion, especially occurring so long after confinement as in Dr. V.'s case, is seldom met with.

Dr. Volkel's patient was a healthy primipara, 32 years old, whom he had delivered, after a somewhat protracted labor, by means of the forceps. There was some slowness in contraction on the part of the uterus, but by proper management the placenta was expelled, and the uterus contracted satisfactorily, remaining in good condition for two days. At the end of that time Dr. V. was summoned in great haste, and found the uterus exposed to the air, completely inverted, and the patient nearly dead from hemorrhage. Application of the proper remedies, stimulants, etc., was made, and the patient subsequently recovered. X.

Poisoning by Poppy-Heads in an Infant cured by Injection of Coffee.—Dr. Kobryner communicates the following case to the *Bull. Gén. de Thérap.*, April 30. He was called to see an infant scarcely three weeks of age, to whom its mother had administered an infusion of poppy-heads with the view of procuring sleep. The child lay pale, immovable, the pupils strongly contracted, almost effaced; the extremities cold; the lips cyanosed. The radial pulse was imperceptible; auscultation alone showed that life still existed. Syrup of ipecac, given by the mouth, failed to produce vomiting. Strong infusion of coffee was then injected into the bowel, while sinapisms were applied to the arms and legs. This procedure was continued for some hours before the little patient showed any sign of life. Finally, however, the pulse reappeared, the cyanosed condition diminished, and eight hours after the commencement of the treatment the child was out of danger.

The quantity of infusion of coffee injected during this period amounted to six pints, at least five pints of which were retained. The following day the child appeared as well as before the accident. X.

Vaccination with Fatal Result.—Krügkula (*Wien. Med. Wochenschr.*, No. 47, 1874) inoculated eight soldiers with vaccine lymph from a foundling-hospital. In two there was no result. In the other six, in whom the vaccine pustule became quickly developed, there occurred chills within twenty-four hours, followed by high fever, weakness, and delirium.

Two to four days after the vaccination, phlegmonous inflammation of the upper arm appeared, in some on one arm, in others on both, which, after a few days, became gangrenous. Two patients were cured, four died. From the same source nine vials were filled with vaccine virus, the use of which caused no evil effects. —*Centralblatt*, March 13. X.

Bromide of Lithium.—M. Rouband draws the following conclusions from his investigations of this drug. Bromide of lithium, as a medicine, has a double effect. It possesses, in a high degree, those lithotriptic properties attributed to the salts of lithia, and, in addition, like other bromides, affects reflex sensibility most energetically. It has not, however, the inconvenient action on the heart displayed by bromide of potassium. Consequently, its place in therapeutics is in the first rank among lithiasics and among sedatives, and its action is particularly valuable in the uric acid diathesis, which is accompanied by painful symptoms, and in neuroses which are so often complicated by the presence of uric acid.—*Bull. Gén. de Thérap.*, April 30. X.

PHILADELPHIA
MEDICAL TIMES.
A WEEKLY JOURNAL OF
MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

PUBLISHED EVERY SATURDAY BY
J. B. LIPPINCOTT & CO.,
715 and 717 Market St., Philadelphia, and 25 Bond St., New York.

SATURDAY, JUNE 5, 1875.

EDITORIAL.

WHY IS IT?

THE Medical Department of the University of Pennsylvania is over one hundred years old, and its professors during the century have filled the world with their personal fame, and made the name of their institution respected wherever learning bears honor. The Scientific Department of the same university was born just three years ago, and, able and learned as are its faculty, is of course comparatively unknown.

The Medical Department of the University, save only in the cabinets which have been bestowed upon it by its professors, is as poor as it was on the day of its birth, not having accumulated one dollar of endowment during a century of most flourishing life. The Scientific Department of the same institution has, during its brief life, obtained immediately available endowments amounting, it is believed, to nearly half a million of dollars, and reversionary rights in estates which, it is said, will be worth in a few years as much more.

Surely this contrast ought to make every lover of medical progress, every believer in his profession, pause to discover why it is.

The reason which we have frequently heard assigned is, that the community is given up to the worship of the mechanic arts and applied science, and does not care for medicine or its interests.

This answer may seem at first plausible, but it is really no better than the plaint of the poor artist, that "the world does not appreciate him." The world cares for nobody, but the world does care for whatever is of value to it; and if this or any other community does not appreciate the medical profession it is because the profession is of no value to it.

It is folly for the profession, and especially for the medical colleges, to account for failure by blaming a community. Just so soon as any one paints good pictures, men will desire them. Especially is it folly in such an institution as the Medical Department of the University of Pennsylvania to lay its poverty to the indifference or niggardliness of a community which has given millions for every conceivable object of charity. Folly, when we recall the towering influence in this community of such men as Rush, and Physick, and Morton, and Parrish, and a host of others, living and dead, who have been connected with this medical department. Folly, under the light of the recent success of a few of the alumni and the professors in raising nearly three-quarters of a million in three or four years for a University hospital.

Instead of looking upon the outside, and laying the blame there, it were better to look upon the inside to find why it is the Medical Department has been so neglected. In doing this, let us also not lose sight of the fact that the Medical Department of the University is simply the type, as she is the mother, of American medical schools: *ex uno disce omnes.*

In an ordinary institution for higher teaching, the theory of constitution is that education is a sacred duty of the community to its members, but can never be made to pay, and must, therefore, be supported either by State aid or by endowments. Unfortunately, or perhaps fortunately, in this country public opinion has generally been opposed to State aid to the highest institutions of learning,—the theory, apparently, being that all citizens should be brought by the State to a certain level and then left to themselves. Public-spirited individuals are more and more supplying this lack of State aid by gifts and legacies amounting in the aggregate to enormous sums. Now, we conceive that the ordinary medical college is so essentially different from other educational institutions in its organization that it can never be classed with them as an eleemosynary institution or attract endowments; and that this is the only reason that none of our medical schools have ever obtained any endowment in this country.

A number of medical gentlemen get together, apply to the Legislature for the right of giving a medical degree, and then produce an annual crop of doctors. Such is the brief history of the rise of a medical school. There are two distinct functions

performed by its professors,—educating in medicine, and giving the right to practise medicine. It is not the first of these that the average student cares for solely, or even chiefly; it is the second that he wants.

If any man doubts this, let him ask himself how many students would any institution get which simply taught medicine and did not give a degree.

It is plain that the medical institution holds a valuable franchise from the Legislature, and expects to make the degrees pay for the medical teaching. The faculty is therefore pretty much on the platform of a firm united together for the purpose of profit. In an institution like Bellevue Medical College, where the faculty is self-appointed, the parallel is exact. In the University or the Jefferson Medical College, the only difference is that the firm has for its supposed advantage given up the power of selecting its own members. Under these circumstances it would be absurd to expect philanthropists to give money to endow medical institutions: as well might they add to the capital of Wanamaker & Brown, P. T. Barnum & Co., or any other combination of men engaged in a laudable effort for gain.

In order to bring the medical colleges into their proper sphere of being simply schools of learning, the various Legislatures ought to take away their power of giving the right to practise, by creating State Examining Boards. But the colleges have it in their own power to place themselves in a position to obtain endowments without any legislative aid. Let them reform medical education by lengthening their courses and raising their standards, and then say to the public, "Medical teaching, properly carried out, can never be self-supporting; we appeal to you for endowments." If this were done, and the enormous influence the profession wields in the aggregate brought to bear, American medical colleges would lead the van, and would not be a by-word and a scoff among the institutions of learning.

CORRESPONDENCE.

Baltimore, May, 1875.

To the Editor of the Philadelphia Medical Times:

DEAR SIR,—It is generally well known that we have in this city two corporations, known to the law as Johns Hopkins Hospital, and Johns Hopkins University. Mr. Hopkins endowed these two institutions with about six millions of dollars, and ever since his death considerable interest has been shown as to the manner in which the two boards of trustees intend to carry out the designs of the donor. The Hospital Board purchased the building and grounds of the old Maryland Hospital for the Insane, demolished the building, piled up the bricks, and rested from their labors, so far as the public could see. This does not necessarily imply that nothing is doing, for we understand that thorough examinations have been made of the principal hospitals in this country and Europe, so that a plan combining all the latest scientific improvements may be selected. It is said that the preparation of a plan is far advanced, and that we may soon expect the buildings to be erected. The University has not progressed very far. Prof. Gilman, of the University of California, has been selected to preside over our new institution. He has been in the city for some weeks past, and a temporary home for the University has been purchased, at a cost of $75,000, on Howard Street, adjoining the new City College. It is said that a proposition has been made to raise the grade in the City College and place it under the University as one of the under-graduate schools. I asked a prominent medical gentleman when he thought the new University would go into operation. He said that "forty generations of worms will feed upon the body of Johns Hopkins before a student enters the doors of the Hopkins University."

There has been much discussion in the papers concerning the character of the proposed school. Because Mr. Hopkins made provision for the gratuitous education of a certain number of students from Maryland, Virginia, and North Carolina, many contend that the course of instruction should be the same as that of our ordinary colleges. We have several colleges of low grade, in which there are free scholarships, and it would seem to be useless to add to the number. The magnificent endowment of the Hopkins University places it in the power of the Board of Trustees to establish an institution which may be a credit to the State and nation. With the funds at their disposal they can command the best men of the country, if not of the world, to fill its chairs; and if the chairs are so filled the students will come. Of low-grade schools and so-called colleges the country has more than enough; of high-grade schools and real universities it has too few. Properly established, there is nothing to hinder the Hopkins University standing at the head of American educational establishments and rivalling those of Germany. As yet, there has been nothing done in regard to the schools of law, theology, medicine, etc. The main question has been to decide whether it shall be an under-graduate or a post-graduate school; whether professors shall be employed on account of their ability to hammer a "little Latin and less Greek" into unwilling college boys, or whether men of established reputation shall have an opportunity to teach their specialties to men capable of understanding and appreciating the instruction. The medical department, if favoritism does not control the selection of the professors, with the Hospital and Convalescent Home as clinical fields to supplement the didactic lectures, ought to become the leading college of the country and afford as good opportunities for obtaining a thorough knowledge of

medicine in all its branches as London, Paris, Berlin, or Vienna.

President Gilman desires the university to be *the* school of the country, and it is to be hoped that nothing may prevent him accomplishing his desire in this respect.

Baltimore is celebrated for the neglect given to sanitary matters. Dickens must certainly have had us in mind when he sketched the "Circumlocution Office," or "how not to do it." For two summers we have endured the intolerable stench of the basin, and it now begins to infect the air. Many plans have been proposed for abating the nuisance (filling up, pumping out, flushing, emptying disinfectants into it), but our city fathers have not advanced beyond the talking stage. And, as if the basin was not enough, we are still blessed with the night-artillery and the bucket-brigade. By what means a thousand men can rule a city of three hundred thousand, and make it endure the vilest odors, is unknown to me, but of the fact we are, alas! convinced. Bah! Yours, etc.,

MEDICUS.

NEW YORK, May 24, 1875.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

SIR,—In the *Times* for May 22, 1875, p. 536, you announce the discovery by Hoppe-Seyler of urobilin among the products of decomposition of blood coloring-matter. This was discovered by myself, and announced two years ago ("Guide to Urinary Analysis," p. 24, note, New York, 1873), as follows:

"As these pages are passing through the press we have met with spectroscopic evidences corroborating the view that the urine-pigment is a derivative of the coloring-matter of the blood, by the discovery, in a solution of decomposing hæmoglobin, of a broad but distinct band of absorption between the Fraunhofer lines *b* and F. This line appears to be identical in position and character with the band discovered by Jaffe (*Virchow's Archiv*, B. 47) in urine and in solutions of urobilin. In the solution of hæmoglobin referred to, the new band was accompanied by the two oxygen blood-bands (between *D* and *E*), and also by the methæ uroglobin band (between *C* and *D*). This association gave a four-banded blood-spectrum, differing from any that we can find on record, and the composite nature of which was evident."

Respectfully, H. G. PIFFARD, M.D.

IRRIGATION OF THE BLADDER.—Dr. Rose, of New York, calls attention, in the *Medical Record* of May 8, to Zeissl's method of introducing liquids into the male bladder without the use of the catheter. The plan is to fit the point of an irrigator into the mouth of the urethra, while the patient is placed on his back, with raised nates, the penis being stretched along the abdominal walls. By the employment of this method Dr. Rose was enabled to inject the bladder with a solution of tannin, having introduced a glass tube into the urethra and connected it with a fountain syringe, which was raised to the height of four feet. Previous attempts to wash out the bladder by means of a catheter had been unsatisfactory.—*Boston Medical and Surgical Journal.*

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, MARCH 25, 1875.

THE PRESIDENT, DR. WM. PEPPER, in the chair.

Multiple hernia.

DR. DE F. WILLARD presented the specimen, which was obtained from A. B., a woman æt. 40. She has had femoral hernia for eight years, wearing a truss, and suffered no serious inconvenience until 6 A.M. on the 27th of January, 1875, when she found that the intestine had protruded and could not be returned. Pain commenced about 8 o'clock, soon after which unsuccessful efforts at taxis were made by a physician. She was admitted to the Presbyterian Hospital at 1 P.M. on the same day. Dr. H. Lenox Hodge attempted reduction, both before and after drawing off the gases, by an aspirator, but both efforts proved unavailing, and by 9 P.M. the loop of intestine had again become greatly distended. The pain, vomiting, etc., became more and more serious, and at 1 A.M. the ordinary operation for the relief of strangulated femoral hernia was performed by Dr. H. It being necessary to open the sac, the bowel was found deeply congested, but its vitality was good, and it was carefully returned into the cavity of the abdomen.

The patient reacted well, but in twelve hours tympanitis appeared, the pulse became rapid and feeble, while nausea, vomiting, and the usual symptoms of peritonitis soon supervened.

Upon the second day she aborted of a two-and-a-half months' fœtus,* after which the symptoms grew rapidly worse until she died, about forty hours after the operation.

Upon examining the cavity of the abdomen, a small amount of effusion was found present, but the existence of general peritonitis was evidenced by lymph glueing together all the intestines and covering in the uterus. The loop of intestine was still in the bent condition in which it was returned, being held loosely by soft lymph, but its calibre was perfectly patulous, and, though congested, it was not at all gangrenous. The internal crural ring was blocked by a mass of fresh lymph, but bore no evidence of being the centre of inflammatory action.

Upon examining the opposite side, it was found that a large loop of the omentum had passed through the left internal abdominal ring, and was fastened in the canal; while at the thyroid foramen existed another epiplocele, the omentum having passed out alongside the obturator vessels to the extent of one and a half inches.

Dr. W. G. PORTER said he was present at the operation. Great efforts were made to reduce the hernia without opening the sac, but this was impossible, and, on opening the sac, numerous adhesions were found.

Cystic medullary cancer of testicle.

Dr. W. S. FORBES presented the specimen, from a man aged 54 years. The patient related that, two years and five months prior to his entrance into the Episcopal Hospital, he had fallen in a fit, and that a few days after the catastrophe his scrotum began to enlarge, and that in a short time it was as large as when the operation for removal of the testicle was performed a few days ago.

On examination, the scrotum measured eleven inches

* This accident was entirely unlooked for, as she had been a widow for five years.

in its vertical or long axis, and eight inches transversely. It presented the appearance of a large hydrocele. The upper half of it was translucent, and the lower part opalescent and thick. The man was very much out of health, and very despondent. There was strongly suspected a diseased testicle at the lower part of the mass. In a short time the opacity of the tumor extended over two-thirds of the scrotum. It was concluded that there was a condition of cachexia, as a consequence of which a blood-vessel had ruptured into the sac, producing the appearance so well described by Percival Pott as sometimes occurring when the walls of a hydrocele become much distended.

On tapping the tumor, very little blood and very little water were drawn off through the canula, although the instrument could be moved about with great freedom, imparting the sensation that would be given in moving it through clots of blood, which strongly suggested hæmatocele. The patient was advised to have the tumor removed, to which he readily assented.

At the consultation with his colleagues, Dr. F. stated his belief in the existence of hæmatocele complicated with malignant disease of the testicle.

On opening the mass, a large quantity of blood and water escaped from the cyst at the upper part, and the testicle was found in the lower part as large as a large orange, and presenting the appearance of medullary cancer.

The history of this case seems to be this: that the man bruised his testicle in the fall he had more than two years ago, that hydrocele was rapidly developed, that the injured testicle was attacked by malignant disease, and that there was ruptured a blood-vessel by distention, giving rise to the opacity in the fluid in the cyst some weeks ago.

The peculiarities of the case are that the patient should have lived over two years with this malignant disease, and that there should have been no metastatic complication, for every other portion of his body appears to be healthy.

The PRESIDENT said he presumed that, as usual, the character of the patient was such that the history could not be relied upon. He thought it quite likely that a large blood-clot had formed, from which the organic parts became removed, and a cystic transformation of the clot occurred. Such a history as this he thought not improbable.

Dr. FORBES replied that not only was this the man's story, but that his wife also insisted upon its accuracy. He had himself no doubt that a decided change had taken place in the tumor since the man fell in convulsions, and also that the testicle was injured at that time; and the growth was, moreover, evidently not recent. It is generally the characteristic of medullary cancer that it grows rapidly, that it is then, perhaps, stationary for a time, and that it finally again grows rapidly, carrying off the patient. From the man's family he could get no other history than that the tumor had been as large for two years as on the day it was removed.

The PRESIDENT asked whether the patient was epileptic.

Dr. FORBES replied that he was not.

The specimen was referred to the Committee on Morbid Growths, which reported, April 8, 1875, as follows:

"In Dr. Forbes's tumor of the testicle we find, upon microscopical examination, large oval alveoli, filled with nucleated epithelial elements; the latter are seen in the various stages of fatty metamorphosis. There is no cylindrical arrangement indicating the presence of any remaining seminiferous tubules, nor is there any proper intercellular substance. The growth is a medullary *carcinoma*."

Enormously enlarged spleen.

Dr. W. G. PORTER presented the specimen, from Mrs. H., white, United States, married, about 40 years of age, mother of five children, the youngest now seven years of age. She always enjoyed good health until 1865, when she went to Norfolk, Virginia, where she contracted a very obstinate form of malarial fever, for which she could never be induced to submit to regular treatment. She never would take quinine, or, in fact, medicine of any kind for any length of time. About 1868 she had a fall, when she felt, as she expressed it, "something give way," and soon began to feel pain in the left side in the region of the spleen, which was accompanied by acid eructations, and considerable gastric and intestinal disturbance. Soon afterwards, a tumor was noticed in the epigastric and left hypochondriac regions, which gradually increased in size until it filled the whole abdominal cavity. About eighteen months ago she was examined by Dr. F. J. Buck and Dr. John S. Parry, of this city, who pronounced the tumor to be an enlarged spleen. She was treated locally by the biniodide of mercury ointment, and the bromide of ammonia internally. Before and since that time she had been treated by many regular physicians; also by homœopaths, and every other variety of quacks; several of whom pronounced it to be an ovarian tumor, and one of whom assured her that the tumor was ovarian, and was very anxious to remove it, assuring her that he could remove it almost without her feeling it. On Friday last, she not only attended to her household duties as usual, but visited an administrator of oxygenated air, who promised to cure her in two weeks. She also attended a furniture-auction, and was on her feet the greater part of the day. On Saturday she complained of great abdominal pain and some difficulty of breathing, which was greatly increased by the recumbent posture.

On Sunday night Dr. Porter saw her for the first time, and found her sitting propped up in bed with pillows, complaining greatly of pain in the abdomen and a feeling of tympanitic distention. Her stomach was very irritable, and she had vomited large quantities of a greenish, bilious-looking fluid. She was much emaciated and thoroughly anæmic. The pulse was weak, and she was evidently extremely ill. Morphia was administered hypodermically, followed by hot applications to the feet and brandy and chlorodyne by the stomach. The anodynes had but little effect in relieving the pain, and on the following day she died.

Autopsy, thirty hours after death.—Body extremely emaciated; abdomen very much enlarged and distended. On opening the abdomen, it was found to be almost entirely filled by a large tumor which lay immediately under the peritoneal coat of the abdominal walls and in front of the intestines. On lifting it up, it was at once seen to be the *spleen*. There were no adhesions between it and the abdominal walls. The weight of the organ on removal was found to be *twenty-one pounds*.

The PRESIDENT said the spleen was the largest ever presented to the Society, and asked Dr. Porter whether there were any adhesions, to which the doctor replied that there were none.

The PRESIDENT said the exhibition of such a tumor brings up the question of extirpation of the organ involved. The absence of adhesions observed here is frequently observed in connection with malarial disease; the changes in the peritoneum being limited usually to capsular thickening. When the organ approaches at all near the size of the present one, treatment has been heretofore an entire failure, and this has been so well recognized that the possibility of extirpation has often been discussed, and the operation actually performed in several instances. As to other forms of

treatment in less advanced cases, hypodermic injections of ergotin seem to have some influence over the contractile element of splenic tumors, though more evidence is needed before the value of this treatment can be determined. He had recently a case of leucocythæmia under observation where there appeared to be a temporary diminution of bulk under this mode of treatment. All treatment by external inunction and internal use of quinine is successful only in comparatively small degrees of enlargement. He would be glad to hear an expression of opinion, with regard to the propriety of operation, from the surgical members of the Society.

Dr. JOHN ASHHURST, JR., said that it was, of course, well known that splenotomy had been performed with success in *traumatic* cases, but no instance had, he believed, occurred, at least in modern times,* in which success had attended the operation when performed for such a condition of the organ as was exhibited in the specimen on the table; death having, indeed, in these cases usually followed in a short time from hemorrhage. In view of such a history as had been read this evening, —the patient carrying this enormously enlarged spleen for years with comparative comfort, and being able to attend to her ordinary avocations,—the surgeon who should propose to operate would, in Dr. A.'s judgment, assume a grave responsibility. The probability of relief from such an operation was so small as to be totally incommensurate with the risk to life.

Dr. FORBES asked to know the relative size of the artery and vein.

Dr. PORTER replied that they had not been examined to this end, and he could not answer, but the vessels remained attached to the tumor, and could be examined.

Dr. R. M. BERTOLET said that if this huge organ was an *ague spleen*, as had been suggested, he thought it of a rare type, as we usually have more thickening of the capsule than is here found. He thought it remarkable that the organ with such a thin covering did not rupture long before it had attained its present size. Another reason against its being a mere ague spleen appeared in the light color it presented instead of the dark pigmented hue of the ague spleen. He was also impressed by the waxy appearance of its cut surface and the translucency of its edges, and asked whether the iodine test for amyloid degeneration had been applied.

The PRESIDENT said that he also had been struck with the points alluded to by Dr. Bertolet, particularly as to the translucency of the edges and the absence of capsular thickening, but he was deterred from mentioning them by the fact that the other viscera were uninfluenced. Further, such extreme enlargement of an albuminoid spleen is rare, while there was also the history of persistent malarial disease previous to the appearance of a tumor. The freedom from suffering and the long maintenance of activity were as remarkable as anything else in the case. In other cases of extreme enlargement, he had observed considerable suffering and great impairment of general health. He shared Dr. Ashhurst's opinion with regard to the impropriety of operating, to a great extent.

Dr. PORTER said that it had changed color since its removal, when it was much darker in hue. It had been preserved in a fluid containing a mixture of salt and saltpetre. The tumor was not diagnosed as an enlarged spleen until eighteen months ago, and Dr. Parry, who made the diagnosis at that time, is now out of town, and no further history could be obtained.

The specimen was referred to the Committee on Morbid Growths, which reported as follows, April 8, 1875:

"The monstrous spleen, presented by Dr. Porter, does not respond to the tests for amyloid reaction. Fresh microscopic sections show the presence of much black pigment-matter in all the splenic tissues. The Malpighian bodies and trabeculæ are not appreciably hypertrophied; the hyperplasis seems to consist solely in an aggregation of blood-corpuscles (chiefly red) in the cavernous sinuses or pulp-substance of the spleen."

Mammary cancer.

Dr. JOHN ASHHURST, Jr., exhibited a specimen of mammary cancer, removed a few hours previously from a married woman, 43 years of age. The right breast was the one affected, and the patient, who had borne several children, attributed the formation of the tumor to a blow which she had received upon the part. The disease had lasted about one year, but had been a source of suffering for only four or five months. The nipple was much retracted, partly on account of a previous mammary abscess, and the skin over the growth was becoming adherent, but there were no deep adhesions and no glandular implication. The mass was removed through an oval incision, care being taken to cut wide of the diseased structures and to remove with the tumor much of the surrounding subcutaneous fat.

Latent cirrhosis of kidneys without albuminuria or dropsy; hypertrophy of heart; dyspnœa; sudden death.

Dr. WILLIAM PEPPER presented the heart and kidneys from a case of latent Bright's disease. The patient was a young woman, æt. 27 years, whose appearance always indicated full health, with some tendency to plethora. It is not known that she ever had scarlatina, and no symptoms had ever attracted attention to the kidneys. For some years past, occasional dyspnœa had been noticed, which grew much more severe last fall, when it became constant, and much increased on exertion. She also had occasional violent paroxysms of orthopnœa, resembling attacks of spasmodic asthma, and usually at night, and, on several occasions, hæmoptysis occurred. The secretion of urine was abundant, of light color, and rather low specific gravity; it was carefully examined several times, but no albumen or tube-casts were found. The breathing was very frequent, and there were frequently signs of marked pulmonary congestion. The action of the heart was habitually rapid, but was readily kept under control by moderate doses of digitalis. Physical examination showed a considerable degree of hypertrophy, chiefly of left ventricle. While under treatment, several severe nocturnal paroxysms occurred; and, finally, after having enjoyed an unusual degree of comfort for several weeks continuously, she was seized with symptoms of intense dyspnœa soon after retiring one evening, followed in a few minutes by insensibility, purplish suffusion of face, and death.

At the autopsy, extreme cirrhosis of both kidneys was found; the organs being reduced to about one-third

* This sentence perhaps requires some explanation. Dr. Otis, U.S.A., the able surgical historian of our late war, has, in the forthcoming second volume of the Surgical History (the advance-sheets of which I have had the privilege of inspecting), collected twenty-six cases of splenotomy, of which only six are said to have terminated fatally. Sixteen cases, in which the operation was performed for *traumatic* causes, all terminated successfully. Of the other four cases in which death did not follow, one belonged to the first half of the sixteenth and one to the first half of the eighteenth century; in the third (Dorsey's) the spleen does not (according to the report in Eve's "Remarkable Cases in Surgery") appear to have been actually removed, but, its adhesions having been broken up, to have been placed "as nearly as possible in what I [the operator] conceived to be its natural position;" while the fourth was Péan's famous case, in which a cystic spleen was removed under the impression that it was an ovarian tumor. Six cases have come to light since Dr. Otis's table was printed, of which four (traumatic cases) are said to have resulted favorably, and one in death, while the termination of the sixth has not been published. Thus, there appears to have been no case reported, during the last one hundred and fifty years, of successful splenotomy for leucocythæmic or malarial disease, while there have been, during the same period, at least seven cases in which the operation performed under these circumstances was the immediate cause of death.—J. A., JR.

their normal size. There was intense venous congestion of all the abdominal organs. The *lungs* were deeply congested, but no apoplectic clots were found. The *heart* was much hypertrophied, the walls of the left ventricle being especially affected. The valves were competent, but the leaflets of the mitral were thickened and somewhat too rigid. The right ventricle was not much enlarged, and its full expansion seemed checked by a delicate band, which passed from about the middle of the septum to the outer wall. There were traces of old pericarditis.

Dr. J. H. HUTCHINSON remarked that some years ago he had exhibited two kidneys which had undergone even greater contraction than had taken place in those just presented by Dr. Pepper, the smaller weighing only seven drachms. The patient, an unmarried woman of about 30 years of age, was admitted into his ward at the Pennsylvania Hospital for a slight disease of the skin. Shortly afterwards, most distressing dyspnœa set in, and continued until the occurrence of death, in less than twenty-four hours after the seizure. Owing to an oversight, the urine was not examined during life, but that which was removed from the bladder after death was found to be highly albuminous. Dr. H. afterwards learned, from the gentleman in whose house she had lived for some time as a servant, that she had apparently always enjoyed good health, and that she had at no time presented symptoms which could be referred to disease of the kidneys. He had known of other cases in which distressing dyspnœa appeared to be dependent upon cirrhosis of these organs and was almost its only manifestation.

Dr. DE F. WILLARD said, with regard to the absence of albumen from urine, he was called last summer to a girl who had not passed water for thirty-one hours, and was suffering from uræmic convulsions. He removed a small quantity by the catheter, but found, on examination, that it was non-albuminous, and without tube-casts. The girl died in three hours. He made a post-mortem examination, and found both kidneys extremely contracted, both smaller than those presented to-night. He re-examined the urine drawn by the catheter very carefully, and found neither albumen nor casts. He could learn little of her previous history (she was a prostitute), but it was said that she had Bright's disease. He had previously seen specimens of urine in which a single examination had failed to point out the presence of albumen, which was subsequently found present.

Dr. JAMES TYSON remarked that the cases just quoted illustrated the form of Bright's disease in which it was well known that albumen is present in minimum amount, and, according to some excellent authorities, sometimes altogether absent. He was confident it was sometimes overlooked when present in very minute quantity, and he desired to call the attention of the members to the extreme delicacy of the so-called Helier's test, in which some urine is either placed in a test-tube, and nitric acid allowed carefully to descend the side of the glass until it underlies it, or, what amounts to the same thing, but is perhaps a little more easy of performance, placing some acid in the tube first, and allowing the urine gently to fall upon it, when, if albumen is present, an opaque white band appears at the border between the two fluids. Within the last two days he was enabled absolutely to prove the presence of albumen in two specimens of urine in which the ordinary methods fail to detect it.

Dr. WILLARD said that in his case he had made use of this test.

Dr. PEPPER also exhibited the specimens from a case of *lymphadenoma* in which transfusion had been performed, and which will be published in a later number of the *Times*.

BIOLOGICAL AND MICROSCOPICAL SECTION OF THE ACADEMY OF NATURAL SCIENCES.

APRIL 5, 1875.

DIRECTOR W. S. W. RUSCHENBERGER, M.D., in the chair.

PRESENT, Messrs. Seiler, Neill, McQuillen, Mortimer, Norris, Kenderdine, Buckingham, Shaeffer, Thomas, Walmsley, Trueman, Reed, and Richardson.

The report of the committee to which was referred Dr. J. Cheston Morris's report on one-twenty-fifth and one-fiftieth objectives, recommending it for publication in the *Philadelphia Medical Times*, was read, accepted, and the committee discharged.

Dr. CARL SEILER read an interesting paper "On the Photographic Enlargements of Microscopic Objects" (see p. 563), illustrated by a large number of his beautiful photo-micrographs. He also exhibited a very complete adaptation to the microscope of the photographic camera, constructed by himself, in which the contrivances for manipulating the fine adjustment, and the stage-movements, were particularly remarkable for ingenuity and efficiency.

The communication was referred to a committee composed of Messrs. McQuillen, Corlies, and Shaeffer.

Mr. WILLIAM H. WALMSLEY displayed a fine Ross microscope, with Wenham's new adaptation of the Jackson model.

Mr. WALMSLEY also exhibited a resplendent slide of butterfly-scales arranged by Mr. Harold Dalton, of Havre, representing birds of brilliant plumage, around an iridescent vase; and one of Möller's new 100 diatom slides, upon which each frustule was arranged above its name in the appropriate compartment of a many-celled photograph prepared for its reception.

Captain MORTIMER, a corresponding member of the Section, displayed a slide of arranged diatoms showing a beautiful monogram of the San Francisco Microscopical Society, prepared for him by Mr. Coles, of Liverpool. Captain M. likewise described a very portable pocket-microscope, made by Browning, of London, at the low price of two guineas, which he proposed to bring before the Section at its next meeting.

Dr. J. H. MCQUILLEN remarked that he had had the pleasure of inspecting this ingenious pocket-microscope belonging to Captain Mortimer, and believed that similar instruments would prove very useful, not only to botanists, and, indeed, to naturalists generally, but especially to physicians, who frequently had occasion to investigate specimens of urine, sputum, blood, etc., at the bedside of patients, or under various circumstances where if an immediate examination were not made the operation could not be satisfactorily performed.

SELECTIONS.

AUDITORY VERTIGO.—The literature and current knowledge of this subject are succinctly presented by Dr. Labadie-Lagrave, in some recent articles in the *Gazette Hebdomadaire*. In a brief historical *résumé* it is shown that, although isolated cases had been reported long ago by Vieussens, and by Itard, Toynbee, and others, it was not until the laborious researches of Ménière that auditory vertigo was recognized as a distinct disease. Since then it has received full attention from numerous investigators, amongst whom may be mentioned Trousseau, who proposed the title *vertigo ab aure læsa*; Duplay, who named it Ménière's disease, a name subsequently adopted by Charcot, Hillairet, Politzer, Voltolini, Knapp, Hinton, and many others. The author

insists that, although the disease derives its name from Ménière, it is not to be forgotten that it is to the experiments of Flourens that we owe a rational explanation of the dependence of the symptoms on the labyrinthine lesion.

The onset is sudden. An individual in the midst of perfect health, and without appreciable cause, is seized with confusion, headache, tinnitus, and vertigo. His gait is uncertain and stumbling; when he rises, objects seem to turn round him; he staggers as if the ground sank beneath his feet. He cannot keep his balance without support, and he executes involuntary movements which impel him in a certain direction. At the same time his hearing is affected; sometimes he can only hear certain sounds. The noises in the ears are very pronounced. He seems to hear the sound of an orchestra, ringing of bells, the rushing of a cascade, or the whistle of a locomotive. Charcot dwells on the intimate relation which exists between the sudden development of noises in the ears, or the sudden exacerbation of these noises, and the onset of the vertigo. Though tinnitus is a common accompaniment of various kinds of vertigo, its intensity and predominance from the very first are characteristic of Ménière's disease.

The face is pale, the forehead bedewed with sweat, the skin cold. Then occur nausea and vomiting, which usually indicate the termination of the attack. The patient can obtain relief only by observing absolute rest in the horizontal position. There is no affection of speech, no spasm of face or extremities. Ménière once saw spasm of the face, followed by incomplete hemiplegia (on the same side as the affected ear), which disappeared in a few days. There is never tingling, numbness, nor any sensation analogous to an aura. These symptoms pass off after a variable time, and reappear sooner or later, each attack increasing the tinnitus and deafness, until the hearing is wholly lost.

The pathological conditions which give rise to auditory vertigo are sufficiently numerous, and some of them at least can be distinguished by the symptoms. In detail they are: 1. Vertigo from traumatic irritation; 2. Vertigo from galvanic excitation; where the electrodes are applied to the mastoid processes the head turns towards the positive pole; 3. Labyrinthine vertigo from internal otitis; of this the author distinguishes three kinds; 4. Vertigo from disease of the middle ear; 5. In rare instances vertigo occurs from obstruction of the auditory meatus; 6. Reflex vertigo; in some persons the access of a drop of water to the membrana tympani brings on a violent attack of giddiness.

Taking otitis labyrinthica as the lesion which gives rise to the most characteristic symptoms, the author proceeds to treat of these latter in two groups, according to the two divisions of the auditory nerve. The vertigo, the sense of rotation or the actual rotation, with their accompaniments, staggering, weakness, pallor, sweating, nausea, vomiting, and headache, are due to lesions of the semicircular canals. On the other hand, the tinnitus, and the gradual and finally complete loss of hearing, are owing to alterations of the cochlea.

To explain the deafness for certain sounds, the author adopts the hypothesis that a limited portion of the cochlea is injured in such cases; and that, as the injured fibres no longer vibrate in response to their corresponding sounds, no impression of these sounds reaches the nervous centre.—*London Medical Record.*

PARET ON THE THERAPEUTIC ACTION OF VALERIANATE OF CAFFEINE.—Dr. Paret, in his *Thèse de Paris*, 1874, No. 464, describes this substance as a product crystallized in white flakes, having a very disagreeable odor like decayed cheese. He has administered it in the form of ten centigramme pills, of which he gives from two to three. It may also be given as a syrup containing ten centigrammes of valerianate of caffeine. Dr. Paret comes to the conclusions: 1. That valerianate of caffeine has, in some cases, appeared to put an end to the nervous vomitings co-existent with hysteria; 2. That this medicine had given to invalids increase of a decided appetite, and a physical as well as moral strength which they had not previously possessed; 3. That the vomitings of consumptive patients had not been checked by it. It has also been tried in the sickness of pregnancy, but without favorable results. It appears that Dr. Labadie-Lagrave has twice used the syrup of valerianate of caffeine for infantile whooping-cough, and that this medicine, taken in doses of two fluidrachms per diem, produced a very marked improvement. The fits of coughing, which at first amounted to fifteen daily, fell to four, after a week's treatment.—*London Medical Record.*

GLEANINGS FROM OUR EXCHANGES.

BRONCHOCELE (*New York Medical Journal*, May, 1875).—Dr. St. John, in an article on Goitre, alludes to the difficulty, and at the same time the necessity, of distinguishing between its different varieties, and mentions the following diagnostic points:

The *follicular* variety may be known by its soft feel, by its limited extent, being confined to lobes or lobules, and (if of long standing) by softening in spots to fluctuation, and therapeutically by its susceptibility to iodine. It affects more frequently the lateral lobes.

The *fibrous* form is *hard* and nodular, but has generally been softer at an earlier stage. The *vascular* form has a soft feel, often pulsates expansively, may have aneurismal thrill, while the varicose variety may show the enlarged veins. The cystic and colloid are the largest variety, the colloid resembling the follicular, but softer, more symmetrical, of slower development, and sometimes giving crepitation, while the cystic gives fluctuation. Exploratory puncture gives albuminous fluid, and it may be unilateral.

Exophthalmic goitre is generally of medium size and symmetrical (though sometimes more of the right lobe, as receiving more directly the impulse of the heart). An essential characteristic of it is alteration of size in connection with relations to pregnancy, menstruation, or mental conditions. It is essentially vascular in nature at first; after a time its structure may change, and the gland become harder, and may even atrophy. Pregnancy will sometimes suspend all the disagreeable symptoms. The general circulatory derangements and constitutional weaknesses make the diagnosis, as a rule, quite easy.

HYSTERICAL AURA.—Professor Charcot maintains, in an article in *L'Union Médicale*, that in most of the crises of hysteria there exists an aura having its point of departure in one of the ovaries, and sometimes in both. This having been determined, it suffices, in order to suspend almost instantaneously the attack, to exercise strong pressure upon the ovary which is the seat of the aura. In a recent conference that was held at the Salpêtrière, M. Charcot showed the efficacy of this procedure in the case of a patient afflicted with hystero-epilepsy. In very many seizures he has suspended at will the attack by compressing the left ovary. The attack is resumed when pressure is removed. In order to exercise compression sufficiently long to avert entirely the attack, M. Charcot employed at the Salpêtrière a kind of tourniquet. Digital compression is made exactly as when one would compress the iliac artery. The fingers are pushed behind the pubes until the pulsation of the artery is felt beneath them.—*Boston Medical and Surgical Journal.*

ULCERATED SCIRRHUS OF THE ŒSOPHAGUS (*New York Medical Journal*, May, 1875).—Dr. Merritt Bishop reports the case of a woman æt. 64, who had always enjoyed robust health, and who noticed suddenly some obstruction in the passage of food to her stomach. She had no pain; pulse and respiration normal. It was found to be utterly impossible to pass even the smallest bougie. The aliment consisted in the use of nutritive enemata. She survived for five days, suffering no pain, but having decided elevation of temperature. Autopsy revealed a perfect healthy condition of all the organs except the œsophagus. The malignant disease began at the cardiac orifice and extended up to the junction of the superior with the middle third, at which point a complete stricture was found, occasioned by adhesions. The surrounding tissues were very much hardened and thickened, pressing hard on the trachea, while the mucous lining was completely destroyed by ulceration.

MISCELLANY.

PARIS SCHOOL OF MEDICINE.—The new School of Medicine in Paris in its reconstruction gives opportunity for an enlargement rendered necessary by the constantly increasing number of the students who attend the courses of the school. To-day there are more than four thousand five hundred pupils. The plan as prepared by the architect, M. Ginain, divides the work into two sections. The first section consists of buildings designed for general studies, and for the administration. The new structures, being joined to the ancient buildings of the school, which were completed in 1786, permit of the preservation of the grand amphitheatre already existing, of the amphitheatres and laboratories of chemistry, of the halls for collections, of a vast library, of offices, and of the apartments for the dean. The second section, designed for the prosecution of practical studies, comprises the buildings of the hospital of clinics in the ancient convent of the Franciscans, and the apartments at present appropriated for pavilions for dissection. The principal divisions are a great amphitheatre for the courses of the faculty, various halls for free instruction, large physiological laboratories, a court for animals, aquariums, and apartments for practical anatomy (halls for dissection, laboratories of histology, of pathological chemistry, etc.); in addition, a museum of pathological anatomy within the ancient refectory of the Franciscans, and, finally, special laboratories for the professors, and various apartments. The entire expense of these works will be scarcely less than nine millions of francs.—*Boston Medical and Surgical Journal.*

MEDICAL DEPARTMENT OF THE UNIVERSITY OF CALIFORNIA.—In regard to the medical department of the University of California, to which attention has been called of late in discussions on medical education, we learn that the school was formerly a private affair, one of the two medical schools in San Francisco; its head man was without high standing in the profession, but possessed of a big fortune and a great reputation in the country. His aim was to perpetuate his name, and he therefore offered his school to the University with the buildings, etc., on condition that it should be called its medical department, naming the building "Toland Hall." The regents soon found that they had received an elephant. The old faculty insisted on becoming the new one, and in it were two professors, one of whom could not write two words correctly; the other, an American, always declared he had a French diploma until some began to doubt it, and he then showed a German diploma, which ultimately proved to be counterfeit. The *San Francisco News Letter* got scent of the scandal and brought it out in its true light, writing to the German university and finding out that no one of that name (Dean) had ever graduated there, and then publishing the letters in its issue. We regret to learn also that there are men in the State and city medical societies who have no diplomas, and yet are tolerated and admired.—*Boston Medical and Surgical Journal.*

FROM the annual report of the "Allgemeine Poliklinik," in Vienna, for 1874, we find that during that year 23,560 persons (3 per cent. of the entire population) sought medical advice from the institution. The number was greatest during July, in which month the daily number of patients averaged 353, on some days mounting up to 500. Diseases of the respiratory system were the most common, after which came, in the order of their frequency, affections of the circulatory, digestive, and nervous systems, and of the skin.

SIGNOR PERUZZI, the Syndic of Florence, has given orders that 800 out of the 1000 dogs annually found straying in that city, which have for some years past been placed at the disposal of Professor Schiff, shall be killed by the police. They are to be asphyxiated instantaneously in a cell constructed for the purpose and filled with carbonic acid gas, which is being prepared in the precincts of the public slaughter-house.—*London Medical Record.*

THE *Deutsche Klinik* has ceased to exist.

NOTES AND QUERIES.

NORTHERN MEDICAL ASSOCIATION OF PHILADELPHIA.

A STATED meeting of the Northern Medical Association of Philadelphia will be held at the hall of the Northern Dispensary, 608 Fairmount Avenue, on Friday evening, June 11, at 8 o'clock.

Subject for discussion: Meningitis. To be introduced by Dr. L. B. Hall. The medical profession are cordially invited.

CHARLES CARTER,
Secretary.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM MAY 25, 1875, TO MAY 31, 1875, INCLUSIVE.

SLOAN, WILLIAM J., SURGEON.—Announced as Medical Director of the Department. G. O. 29, Department of Dakota, May 4, 1875.

KNICKERBOCKER, B., ASSISTANT-SURGEON.—The order directing him to proceed to Fort Colville, W. T., is revoked, and he is assigned to temporary duty at Fort Vancouver, W. T. S. O. 60, Department of the Columbia, May 11, 1875.